		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041186

Facility Name: Tri-State Nsg & Rehab Ctr

Address: 2500 W. 175Th Street (Number) Lansing (City) 60438 (Zip Code)

County: Cook

Telephone Number: (708) 474-7330 **Fax #** (708) 474-7391

IDPA ID Number: 364034144001

Date of Initial License for Current Owners: 09/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 4/1/04

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	28	Skilled (SNF)	56	17,948	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	28	12,796	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,744	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,827	346	4,775	17,948	8
9	SNF/PED					9
10	ICF	3,833	5,264	331	9,428	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,660	5,610	5,106	27,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.05%

D. How many bed-hold days during this year were paid by Public Aid? 6 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 4,444

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	170,722	21,609	10,432	202,763		202,763	(2,088)	200,675			1
2	Food Purchase		116,732		116,732	(4,904)	111,828	1,075	112,903			2
3	Housekeeping	98,678	24,397		123,075		123,075	(3,749)	119,326			3
4	Laundry	74,953	11,153		86,106		86,106		86,106			4
5	Heat and Other Utilities			80,497	80,497		80,497	709	81,206			5
6	Maintenance	37,891	17	66,644	104,552		104,552	996	105,548			6
7	Other (specify):*							1,092	1,092			7
8	**TOTAL General Services**	382,244	173,908	157,573	713,725	(4,904)	708,821	(1,964)	706,856			8
	B. Health Care and Programs											
9	Medical Director			12,500	12,500		12,500	(500)	12,000			9
10	Nursing and Medical Records	1,267,659	28,003	8,322	1,303,984		1,303,984	3,816	1,307,800			10
10a	Therapy	104,051		547	104,598		104,598		104,598			10a
11	Activities	86,740	5,226	784	92,750		92,750		92,750			11
12	Social Services	71,255		2,074	73,329		73,329	5,100	78,429			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							2,648	2,648			15
16	**TOTAL Health Care and Programs**	1,529,705	33,229	24,227	1,587,161		1,587,161	11,064	1,598,225			16
	C. General Administration											
17	Administrative	73,275		4,781	78,056		78,056	6,541	84,597			17
18	Directors Fees											18
19	Professional Services			162,956	162,956		162,956	(120,612)	42,344			19
20	Dues, Fees, Subscriptions & Promotions			21,096	21,096		21,096	(9,310)	11,786			20
21	Clerical & General Office Expenses	57,603	10,069	146,291	213,963		213,963	(39,572)	174,391			21
22	Employee Benefits & Payroll Taxes			397,318	397,318	4,904	402,222	(23,146)	379,076			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,831	1,831		1,831	1,927	3,758			24
25	Other Admin. Staff Transportation			994	994		994		994			25
26	Insurance-Prop.Liab.Malpractice			76,611	76,611		76,611	423	77,034			26
27	Other (specify):*							12,597	12,597			27
28	**TOTAL General Administration**	130,878	10,069	811,878	952,825	4,904	957,729	(171,152)	786,577			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,042,827	217,206	993,678	3,253,711		3,253,711	(162,052)	3,091,659			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr #0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			37,383	37,383		37,383	161,206	198,589			30
31	Amortization of Pre-Op. & Org.							7,803	7,803			31
32	Interest			7,117	7,117		7,117	67,077	74,194			32
33	Real Estate Taxes			176,938	176,938		176,938	876	177,814			33
34	Rent-Facility & Grounds			337,260	337,260		337,260	(334,840)	2,420			34
35	Rent-Equipment & Vehicles			2,588	2,588		2,588	(345)	2,243			35
36	Other (specify):*											36
37	**TOTAL Ownership**			561,286	561,286		561,286	(98,223)	463,063			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,233	200,489	346,722		346,722	(9,255)	337,467			39
40	Barber and Beauty Shops			24	24		24	(24)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,242	46,242		46,242	(126)	46,116			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		146,233	246,755	392,988		392,988	(9,405)	383,583			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,042,827	363,439	1,801,719	4,207,985		4,207,985	(269,680)	3,938,305			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	76,519	30		9
10	Interest and Other Investment Income	(83,816)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(236)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,000)	21		24
25	Fund Raising, Advertising and Promotional	(1,615)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(17,241)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(9)	20		28
29	Other-Attach Schedule	(134,721)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (201,119)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(68,562)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (68,562)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (269,680)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Tri-State Nsg & Rehab Ctr
ID# 0041186
Report Period Beginning: 01/01/04
Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (5,752)	21	1
2	Jury Duty Income	(652)	10	2
3	Patient Clothing	(215)	10	3
4	Barber & Beauty	(24)	40	4
5	Theft Loss	(306)	21	5
6	Collection Expense	(112)	21	6
7	COPE Dues	(1,348)	20	7
8	Assisted Living Parcel Real Estate Tax	(2,663)	33	8
9	Late Fees	(555)	06	9
10	Non-Allowable Legal	(733)	19	10
11	Accrued Legal Fees	1,938	19	11
12	Duplicate Legal Fees	(980)	19	12
13	PPA - Office	(183)	21	13
14	PPA - Pension Expense	(19,184)	22	14
15	PPA - Medical Director	(500)	9	15
16	Excess Bed Tax	(126)	42	16
17	Capitalized R&M	(1,747)	06	17
18	Rental Income	(1,200)	35	18
19	Building Company - Bank Charges	(31)	21	19
20	Building Company - Trust Fees	(250)	21	20
21	Non-Allowable Expense	(45,410)	21	21
22	Non-Allowable Interest	(54,688)	32	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
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93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(134,721)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(101)	186		(1,373)	(800)				(2,088)	1
2	Food Purchase	(236)							1,311				1,075	2
3	Housekeeping				(3,749)								(3,749)	3
4	Laundry													4
5	Heat and Other Utilities					709							709	5
6	Maintenance	(2,302)				757		2,526	15				996	6
7	Other (specify):*						270	617	205				1,092	7
8	**TOTAL General Services**	(2,538)			(3,850)	1,652	270	1,770	731				(1,964)	8
	B. Health Care and Programs													
9	Medical Director	(500)											(500)	9
10	Nursing and Medical Records	(867)			(4,144)			8,827					3,816	10
10a	Therapy													10a
11	Activities													11
12	Social Services							5,100					5,100	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						610	2,038					2,648	15
16	**TOTAL Health Care and Programs**	(1,367)			(4,144)		610	15,965					11,064	16
	C. General Administration													
17	Administrative							6,441	100				6,541	17
18	Directors Fees													18
19	Professional Services	225				(120,847)			10				(120,612)	19
20	Fees, Subscriptions & Promotions	(2,972)				(6,344)			6				(9,310)	20
21	Clerical & General Office Expenses	(109,285)	281		(317)	6,917		62,651	181				(39,572)	21
22	Employee Benefits & Payroll Taxes	(19,184)		(403)	(19)		(3,540)						(23,146)	22
23	Inservice Training & Education													23
24	Travel and Seminar					1,882			45				1,927	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					384			39				423	26
27	Other (specify):*						2,572	10,025					12,597	27
28	**TOTAL General Administration**	(131,216)	281	(403)	(336)	(118,008)	(968)	79,117	381				(171,152)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(135,121)	281	(403)	(8,330)	(116,356)	(88)	96,852	1,112				(162,052)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	76,519	76,346			7,031				1,310			161,206	30
31	Amortization of Pre-Op. & Org.		7,803										7,803	31
32	Interest	(138,504)	205,429						6	146			67,077	32
33	Real Estate Taxes	(2,663)	2,663			876							876	33
34	Rent-Facility & Grounds		(337,260)			2,211			209				(334,840)	34
35	Rent-Equipment & Vehicles	(1,200)				850			5				(345)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(65,848)	(45,019)			10,968			220	1,456			(98,223)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(3,405)				(3,140)	(2,710)			(9,255)	39
40	Barber and Beauty Shops	(24)											(24)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(126)											(126)	42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(150)			(3,405)				(3,140)	(2,710)			(9,405)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(201,119)	(44,738)	(403)	(11,735)	(105,388)	(88)	96,852	(1,808)	(1,254)			(269,680)	45

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Lansing Healthcare Properties		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 337,260	Lansing Healthcare Properties	100.00%	$	$ (337,260)	1
2	V	21	Bank Charges		Lansing Healthcare Properties	100.00%	31	31	2
3	V	21	Land Trust Fee		Lansing Healthcare Properties	100.00%	250	250	3
4	V	30	Depreciation		Lansing Healthcare Properties	100.00%	76,346	76,346	4
5	V	31	Amortization		Lansing Healthcare Properties	100.00%	7,803	7,803	5
6	V	33	Real Estate Tax		Lansing Healthcare Properties	100.00%	2,663	2,663	6
7	V	32	Interest - Fairfax		Lansing Healthcare Properties	100.00%	54,688	54,688	7
8	V	32	Interest - Cole Taylor		Lansing Healthcare Properties	100.00%	150,741	150,741	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 337,260			$ 292,522	$ * (44,738)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 74,264	$ 74,264	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	74,667	CCS EMPLOYEE BENEFIT GROUP	100.00%		(74,667)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,667			$ 74,264	$ * (403)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 680	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 579	$ (101)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	25,268	XCEL MEDICAL SUPPLY, LLC	100.00%	21,519	(3,749)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10	NURSING	27,931	XCEL MEDICAL SUPPLY, LLC	100.00%	23,787	(4,144)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE	2,139	XCEL MEDICAL SUPPLY, LLC	100.00%	1,821	(317)	23
24	V	22	EMPLOYEE BENEFITS	128	XCEL MEDICAL SUPPLY, LLC	100.00%	109	(19)	24
25	V	39	ANCILLARY	22,949	XCEL MEDICAL SUPPLY, LLC	100.00%	19,544	(3,405)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 79,095			$ 67,360	$ * (11,735)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 186	$ 186	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	709	709	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	757	757	17
18	V	10	Nursing		Care Centers, Inc.	100.00%			18
19	V	11	Activities		Care Centers, Inc.	100.00%			19
20	V	19	Professional Fees	124,665	Care Centers, Inc.	100.00%	3,818	(120,847)	20
21	V	20	Dues and Subscriptions	7,665	Care Centers, Inc.	100.00%	1,321	(6,344)	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	6,917	6,917	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	1,882	1,882	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	384	384	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	7,031	7,031	25
26	V	32	Interest		Care Centers, Inc.	100.00%			26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	876	876	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	2,211	2,211	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	850	850	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 132,330			$ 26,942	$ * (105,388)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 1,848	Care Centers, Inc.	100.00%	$ 1,848	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	270	270	16
17	V	10	Nursing Salary	2,176	Care Centers, Inc.	100.00%	2,176		17
18	V	10a	Rehab Salary	419	Care Centers, Inc.	100.00%	419		18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary	1,575	Care Centers, Inc.	100.00%	1,575		20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	610	610	21
22	V	17	Administration Salary	2,191	Care Centers, Inc.	100.00%	2,191		22
23	V	21	Office Salary	15,392	Care Centers, Inc.	100.00%	15,392		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	2,572	2,572	24
25	V	22	Employee Benefits	3,540	Care Centers, Inc.	100.00%		(3,540)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 27,141			$ 27,053	$ * (88)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 3,066	Care Centers, Inc.	100.00%	$ 1,693	$ (1,373)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	2,526	2,526	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	617	617	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	8,827	8,827	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	5,100	5,100	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	2,038	2,038	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	6,441	6,441	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	62,651	62,651	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	10,025	10,025	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,066			$ 99,918	$ * 96,852	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 2,590	Care Centers, Inc. - Health Systems Division	100.00%	$ 389	$ (2,201)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	1,311	1,311	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	15	15	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	100	100	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	10	10	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	6	6	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	181	181	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	45	45	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	39	39	23
24	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	6	6	24
25	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	209	209	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	5	5	26
27	V	39	Ancillary Enteral Supplies	6,358	Care Centers, Inc. - Health Systems Division	100.00%	3,218	(3,140)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,401	1,401	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	205	205	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,948			$ 7,140	$ * (1,808)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 1,310	$ 1,310	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	146	146	16
17	V	39	Vent Reimbursement	2,710	Vent Lease, LLC.	100.00%		(2,710)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,710			$ 1,456	$ * (1,254)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Eric Rothner	Owner	Administrative	1.19%	See Attached	0.60	1.30%	Mgmt Fee	$ 2,590	17-3	1
2	Adam Vales	Relative	Clerical		See Attached	0.48	1.20%	Alloc Salary	501	22-7	2
3	Norman Goldberg	Owner	Administrative	4.76%	See Attached	1.50	3.00%	Alloc Salary	1,798	17-7	3
4	Mark Steinberg	Relative	Administrative		See Attached	1.00	1.82%	Alloc Salary	1,155	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,044		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 WEST MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 74,264	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 74,264	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 579	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						21,519	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation							5
6	10	NURSING	Direct Allocation						23,787	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation						1,821	9
10	22	EMPLOYEE BENEFITS	Direct Allocation						109	10
11	39	ANCILLARY	Direct Allocation						19,544	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 67,360	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,484,397	42	$ 9,730	$	28,372	$ 186	1
2	05	Utilities	Patient Days	1,484,397	42	37,103		28,372	709	2
3	06	Maintenance	Patient Days	1,484,397	42	39,622		28,372	757	3
4	10	Nursing	Patient Days	1,484,397	42			28,372		4
5	11	Activities	Patient Days	1,484,397	42			28,372		5
6	19	Professional Fees	Patient Days	1,484,397	42	199,755		28,372	3,818	6
7	20	Dues and Subscriptions	Patient Days	1,484,397	42	69,116		28,372	1,321	7
8	21	Office & Clerical	Patient Days	1,484,397	42	361,868		28,372	6,917	8
9	24	Travel and Seminar	Patient Days	1,484,397	42	98,454		28,372	1,882	9
10	26	Insurance	Patient Days	1,484,397	42	20,081		28,372	384	10
11	30	Depreciation	Patient Days	1,484,397	42	367,842		28,372	7,031	11
12	32	Interest	Patient Days	1,484,397	42			28,372		12
13	33	Real Estate Taxes	Patient Days	1,484,397	42	45,838		28,372	876	13
14	34	Rent - Building	Patient Days	1,484,397	42	115,677		28,372	2,211	14
15	35	Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		28,372	850	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,409,572	$		$ 26,942	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			264,919	264,919		1,848	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			38,757			270	2
3	10	Nursing Salary	Direct Cost			209,584	209,584		2,176	3
4	10a	Rehab Salary	Direct Cost			66,982	66,982		419	4
5	11	Activity Salary	Direct Cost							5
6	12	Social Service Salary	Direct Cost			66,710	66,710		1,575	6
7	15	Emp. Ben. - Healthcare	Direct Cost			50,220			610	7
8	17	Administration Salary	Direct Cost			38,431	38,431		2,191	8
9	21	Office Salary	Direct Cost			525,935	525,935		15,392	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			82,566			2,572	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,344,103	$ 1,172,560		$ 27,053	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	28,372	1,693	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42			28,372		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	28,372	2,526	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		28,372	617	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	28,372	8,827	5
6	10a	Rehab Salary	Patient Days	1,484,397	42			28,372		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	28,372	5,100	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		28,372	2,038	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	336,976	28,372	6,441	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	28,372	62,651	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		28,372	10,025	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,227,610	$ 4,564,232		$ 99,918	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835		93,149		8,948	389	1
2	02	Food	Billable Income	2,144,835		987,169		8,948	1,311	2
3	06	Maintenance	Billable Income	2,144,835		3,597		8,948	15	3
4	17	Administration	Billable Income	2,144,835		24,000		8,948	100	4
5	19	Professional Fees	Billable Income	2,144,835		2,500		8,948	10	5
6	20	Dues & Subscriptions	Billable Income	2,144,835		1,342		8,948	6	6
7	21	Office & Clerical	Billable Income	2,144,835		43,384		8,948	181	7
8	24	Travel & Seminar	Billable Income	2,144,835		10,755		8,948	45	8
9	26	Insurance	Billable Income	2,144,835		9,262		8,948	39	9
10	32	Interest Expense	Billable Income	2,144,835		1,371		8,948	6	10
11	34	Rent - Building	Billable Income	2,144,835		50,000		8,948	209	11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835		1,080		8,948	5	12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		8,948	3,218	13
14	01	Dietary - Salary	Billable Income	2,144,835		335,801	335,801	8,948	1,401	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		8,948	205	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,711,055	$ 335,801		$ 7,140	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	620,670	29	$ 300,000	$	2,710	$ 1,310	1
2	32	Interest	Direct Billing	620,670	29	33,493		2,710	146	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 333,493	$		$ 1,456	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cole Taylor Bank		X	Mortgage	$22,010.00	9/1/95	$ 2,620,000	$ 1,990,849			$ 150,741	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Corus Bank		X								7,117	6
7												7
8	See Supplemental Schedule							505,000			152	8
9	TOTAL Facility Related				$22,010.00		$ 2,620,000	$ 2,495,849			$ 158,010	9
	B. Non-Facility Related*											
10	Interest Income										(83,816)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (83,816)	14
15	TOTALS (line 9+line14)						$ 2,620,000	$ 2,495,849			$ 74,194	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc from Care Centers		X				$	$			$ 6	8
9	Alloc from Vent Lease		X								146	9
10	Fairfax HC Properties	X						505,000			54,688	10
11	Adjusted page 5										(54,688)	11
12												12
13												13
14	TOTAL Working Capital							505,000			152	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	135,727	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	156,062	2
3. Under or (over) accrual (line 2 minus line 1).	$	20,335	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	160,142	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	180,477	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	126,918	8
	2000	128,577	9
	2001	133,605	10
	2002	129,274	11
	2003	152,523	12

2004 Accrual = 2003 Tax $152,523 x 1.05 = $160,142

Care Centers allocation $876

RE Tax Assisted Living Parcel $2,663 - adjusted out page 5

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-30-304-018-0000	Non-Care Property	$ 2,663.31	$
2.	30-30-305-035-0000	Long Term Care Property	$ 152,523.11	$ 152,523.11
3.	See Attached	Home Office Allocation	$ 106,873.39	$ 876.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 262,059.81	$ 153,399.11

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,244 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living Facility

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 40,639
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 7,803
4. Dates Incurred: _____

Nature of Costs: Closing Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 84,986	1
2	2201 Main LLC allocation			6,722	2
3	TOTALS			$ 91,708	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	24,431		20	1,222	1,222	11,323	9
10	Various			1996	82,791		20	4,140	4,140	36,135	10
11	Various			1997	44,854		20	2,245	2,245	16,859	11
12	Various			1998	47,497		20	2,478	(2,478)	16,996	12
13	Various			1999	39,389		20	1,972	1,972	11,274	13
14	Various			2000	13,995		20	701	701	3,119	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,932,035	76,346		146,602	70,256	775,265	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		25,933	1,066		1,066		2,212	68
69	Financial Statement Depreciation			7,569			(7,569)		69
70	TOTAL (lines 4 thru 69)		$ 3,210,925	$ 84,981		$ 160,426	$ 70,489	$ 873,183	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,210,925	$ 84,981		$ 160,426	$ 75,445	$ 873,183	1
2	Repairs Walk In Free	2001	595		20	30	30	112	2
3	Hvac	2001	635		20	32	32	114	3
4	Compressor	2001	2,292		20	115	115	402	4
5	Partial Replace-Roof	2001	1,950		20	98	98	342	5
6	Metal Chimney Flash	2001	550		20	28	28	95	6
7	Repair Heating Syste	2001	1,344		20	67	67	224	7
8	60 Gal Paint	2001	779		20	39	39	124	8
9	Cctv System	2001	5,325		20	266	266	1,065	9
10	Switch & Piping Mate	2001	1,376		20	69	69	269	10
11	Bearing Motor & Asse	2001	892		20	45	45	175	11
12	Replace Air Filters	2001	1,021		20	51	51	196	12
13	A/C Tune Up	2001	1,959		20	98	98	359	13
14	Grease Trap In Kitch	2001	685		20	34	34	126	14
15	Repair Hvac	2001	1,218		20	61	61	198	15
16	Paint	2002	1,067		20	107	107	320	16
17	Corner Guards	2002	876		20	88	88	263	17
18	Paint	2002	916		20	92	92	275	18
19	Valve Replacement	2002	1,130		20	113	113	301	19
20	Install Exit & Emerg. Lights	2002	860		20	172	172	444	20
21	Paint	2002	818		20	82	82	198	21
22	Decorating-Paint	2002	543		20	54	54	127	22
23	Paint	2002	2,143		20	107	107	223	23
24	Boiler Repair	2003	4,263		20	355	355	711	24
25	Heating Equip.	2003	501		20	25	25	48	25
26	Boiler Equip.	2003	500		20	25	25	48	26
27	Hot Water Heating Coils	2003	2,464		20	164	164	274	27
28	Fixed Broken Piping	2003	835		20	56	56	88	28
29	Air Condition Start Up	2003	1,919		20	96	96	152	29
30	Exhaust System For Oxygen	2003	2,150		20	215	215	305	30
31	Generator Maint.	2003	1,445		20	72	72	102	31
32	Awning Roto Gear Operator	2003	1,916		20	192	192	271	32
33	Garden Work	2003	998		20	100	100	141	33
34	TOTAL (lines 1 thru 33)		$ 3,256,890	$ 84,981		$ 163,574	$ 78,593	$ 881,275	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,256,890	$ 84,981		$ 163,574	$ 78,593	$ 881,275	1
2	Exterior Repairs	2003	1,541		20	154	154	205	2
3	Faucet And Back Splash	2003	934		20	47	47	62	3
4	Water Heater Repair	2003	1,112		20	56	56	65	4
5	Seco Refrigeration-Boiler Repairs	2004	802		20	160	160	160	5
6	Weather Temp	2004	939		20	94	94	94	6
7	Roof Repairs	2004	2,200		20	220	220	220	7
8	Screens	2004	800		20	80	80	80	8
9	Sprinkler	2004	1,512		20	151	151	151	9
10	Eltek Corp.-Hvac	2004	1,265		20	253	253	253	10
11	Heating Coil	2004	2,055		20	171	171	171	11
12	Electrical Repairs	2004	766		20	57	57	57	12
13	Cement Work	2004	2,887		20	120	120	120	13
14	Eltek Corp.-Ac Condensing Unit	2004	3,224		20	269	269	269	14
15	Generator	2004	601		20	50	50	50	15
16	Parking Signs	2004	555		20	14	14	14	16
17	Interior Remodel	2004	17,647		20	441	441	441	17
18	New Driveway	2004	4,960		20	124	124	124	18
19	Hvac Repair	2004	1,484		20	12	12	12	19
20	Roofing	2004	1,100		20	9	9	9	20
21	Warewasher Motor, Impelloer	2004	1,289		20	11	11	11	21
22	Construction	2004	35,557		20	296	296	296	22
23	Cubicle Curtain	2004	1,288		20	64	64	64	23
24	Hvac - Saddle Valve	2004	628		20	3	3	3	24
25	Hvac - Motor, Fan Blade	2004	588		20	12	12	12	25
26	Repair Hot Water Line	2004	530		20	24	24	24	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,343,154	$ 84,981		$ 166,466	$ 81,485	$ 884,242	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	84		1995	1962	$ 2,932,035	$ 76,346	20	$ 146,602	$ 70,256	$ 775,265	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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54									54
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,932,035	$ 76,346		$ 146,602	$ 70,256	$ 775,265	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC		2002		$ 9,263	$ 232	40	$ 232	$	$ 579	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	7,652	383	20	383		957	9
10	Allocation - 2201 Main LLC			2003	9,018	451	20	451		676	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
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69									69
70	TOTAL (lines 4 thru 69)		$ 25,933	$ 1,066		$ 1,066	$	$ 2,212	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 222,349	$ 16,740	$ 24,322	$ 7,582	10	$ 159,727	71
72	Current Year Purchases	39,372	19,370	6,822	(12,548)	10	6,822	72
73	Fully Depreciated Assets	10,061				10	10,061	73
74								74
75	TOTALS	$ 271,782	$ 36,110	$ 31,144	$ (4,966)		$ 176,610	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	1997	$ 47,208	$	$	$	5	$ 35,408	76
77		Care Centers Allocation		13,254	979	979		5	11,024	77
78										78
79										79
80	TOTALS			$ 60,462	$ 979	$ 979	$		$ 46,432	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,767,106	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 122,070	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 198,589	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 76,519	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,107,284	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Centers				2,420			5
6								6
7	TOTAL				$ 2,420 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 2,243 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 97,550	$		$ 97,550	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			5,986			5,986	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			96,953			96,953	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				100,090		100,090	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						46,143		46,143	13
14	TOTAL			$		$ 200,489	$ 146,233		$ 346,722	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,557	$ 98,077	1
2	Cash-Patient Deposits	23,850	23,850	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	825,315	961,042	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,982	101,982	6
7	Other Prepaid Expenses	4,371	4,371	7
8	Accounts Receivable (owners or related parties)		111,452	8
9	Other(specify): See Attached Schedule	1,304,344	1,304,344	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,272,419	$ 2,605,118	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		115,041	13
14	Buildings, at Historical Cost		2,977,499	14
15	Leasehold Improvements, at Historical Cost	338,767	338,767	15
16	Equipment, at Historical Cost	311,800	481,773	16
17	Accumulated Depreciation (book methods)	(331,957)	(1,206,939)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	938	97,855	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 319,548	$ 2,803,996	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,591,967	$ 5,409,114	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 504,835	$ 640,562	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,457	18,457	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,584	83,584	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,190	3,190	31
32	Accrued Real Estate Taxes(Sch.IX-B)	160,142	160,142	32
33	Accrued Interest Payable		111,023	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	230,211		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,000,419	$ 1,016,958	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		505,000	39
40	Mortgage Payable		1,990,849	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,495,849	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,000,419	$ 3,512,807	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,591,548	$ 1,896,307	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,591,967	$ 5,409,114	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,249,653	1
2	Restatements (describe):		2
3	See Attached	26,363	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,276,016	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	315,532	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 315,532	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,591,548	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,340,724	1
2	Discounts and Allowances for all Levels	(1,162,687)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,178,037	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,067,563	6
7	Oxygen	239	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,067,802	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,200	16
17	Sale of Drugs	116,486	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,790	19
20	Radiology and X-Ray	4,700	20
21	Other Medical Services	24,282	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 187,458	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	83,816	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 83,816	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	6,404	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,404	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,523,517	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	713,725	31
32	Health Care	1,587,161	32
33	General Administration	952,825	33
	B. Capital Expense		
34	Ownership	561,286	34
	C. Ancillary Expense		
35	Special Cost Centers	346,746	35
36	Provider Participation Fee	46,242	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,207,985	40
41	**Income before Income Taxes (line 30 minus line 40)****	315,532	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 315,532	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,989	2,162	$ 72,932	$ 33.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,697	7,589	193,957	25.56	3
4	Licensed Practical Nurses	21,364	23,598	493,733	20.92	4
5	Nurse Aides & Orderlies	47,714	50,396	482,881	9.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,467	6,813	104,051	15.27	8
9	Activity Director	1,950	2,412	31,609	13.10	9
10	Activity Assistants	6,437	7,094	55,131	7.77	10
11	Social Service Workers	3,518	4,130	71,255	17.25	11
12	Dietician					12
13	Food Service Supervisor	1,893	2,131	31,976	15.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,263	15,563	138,746	8.92	15
16	Dishwashers					16
17	Maintenance Workers	1,974	2,273	37,891	16.67	17
18	Housekeepers	10,530	11,777	98,678	8.38	18
19	Laundry	6,458	7,412	74,953	10.11	19
20	Administrator	1,879	1,995	73,275	36.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,738	6,238	57,603	9.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,985	2,175	24,156	11.11	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	140,856	153,758	$ 2,042,827 *	$ 13.29	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	164	$ 7,366	01-03	35
36	Medical Director	monthly	12,500	09-03	36
37	Medical Records Consultant	monthly	4,816	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,330	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	784	11-03	44
45	Social Service Consultant	9	499	12-03	45
46	Other(specify)				46
47					47
48	CCI (see attached)		7,364	various	48
49	TOTAL (lines 35 - 48)	189	$ 34,659		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Zaruba	Administrator	0	$ 73,275
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,275

B. Administrative - Other

Description	Amount
Eric Rothner - Management Fee	$ 2,590
Administrative payroll paid through Care Centers	2,191
TOTAL (agree to Schedule V, line 17, col. 3)	$ 4,781
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Care Centers Inc.	Home Office Expense	$ 70,560
Care Centers Inc.	Ancillary Admin. Services	10,080
Care Centers Inc.	Bookkeeping	17,136
ADP	Payroll	6,466
Care Centers Inc.	Data Processing	3,024
Frost Ruttenberg & Rothblatt	Accounting	18,000
Care Centers Inc.	Accounting	15,000
Care Centers Inc.	Legal	7,665
Various - see attached	Legal	3,964
Personnel Planners	Unemployment Consultant	2,928
Care Centers Inc.	Professional Fees	1,200
See Supplemetal Schedule		6,933
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 162,956

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,550
Unemployment Compensation Insurance	26,315
FICA Taxes	156,042
Employee Health Insurance	101,243
Employee Meals	4,904
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	10,921
Other Employee Benefits	4,106
Holiday Expense	1,995
TOTAL (agree to Schedule V, line 22, col.8)	$ 379,076

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 563
Advertising: Employee Recruitment	1,215
Health Care Worker Background Check	
(Indicate # of checks performed 58)	2,821
Dues & Subscriptions	3,358
Licenses & Fees	2,502
Advertising & Promotion	9,280
Yellow Page Advertising	9
Allocated from Care Centers	1,327
Less: Public Relations Expense	( )
Non-allowable advertising	(9,280)
Yellow page advertising	(9)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,786

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,752
Educational Expense	79
Allocation from Care Centers	1,927
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,758

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr **#** 0041186 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $3687**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,654** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **46,116**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,904** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.